

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13659

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13638

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>6 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13 Cambridge</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>501 Maryland Ave.,</b>				d. STREET ADDRESS <b>501 Maryland Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ralph</b> Middle <b>Rodgers</b> Last <b>Adkins</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>14</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 9, 1906</b>	9. AGE (In years last birthday) <b>53 yrs.</b>	IF UNDER 1 YEAR Months <b>53</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supt. Maintenance at Hospital, retired</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Bloomington, Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>Benjamin E. Adkins</b>			14. MOTHER'S MAIDEN NAME <b>Mary Ann Webb</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>307-14-2125</b>		17. INFORMANT Address <b>Mrs. Margaret D. Adkins, 501 Maryland Ave., Camb., Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John Mace Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Dr. John Mace Jr.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>12/15/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec. 17, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Christ Church Cemetery</b>		22d. LOCATION (City, town, or county) <b>Cambridge, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kenneth R. Thomas</i>				24a. REC'D BY REGISTRAR DATE <b>DEC 21 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13675

CERTIFICATE OF DEATH

13639

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md. R.F.D. # 3</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md. R.F.D. # 3.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Margie</u> Middle <u>E</u> Last <u>Barnes</u>			4. DATE OF DEATH Month <u>12</u> Day <u>17</u> Year <u>59</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/22/1879</u>		9. AGE (In years last birthday) <u>80</u> yrs.	10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Daniel Lambdin</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Le Compte Funeral Service, Records.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> <u>442x</u> DUE TO <u>renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic hypertensive cardion vascular</u> DUE TO <u>1 year +</u> (c) <u>Arteriosclerosis, generalized</u> DUE TO <u>1 year +</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I attended the deceased from <u>9-17</u> , 19 <u>59</u> , to <u>12-17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12-17-59</u> , 19 <u>  </u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Eldridge H. Wolff</u> M.D. <u>15 Locust Street, Cambridge, Md.</u> <u>12-18-59</u> PHYSICIAN'S NAME (Type) <u>Eldridge H. Wolff, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/19/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brick Church</u>		22d. LOCATION (City, town, or county) (State) <u>Taylors Island, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 29 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Hanna</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13660

## CERTIFICATE OF DEATH

Reg. Dist. No.

13640

1. PLACE OF DEATH o. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. LENGTH OF STAY IN 1b <b>43 hrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge Maryland Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Beasley</b>				4. DATE OF DEATH Month Day Year <b>December 5 1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 4, 1959</b>		9. AGE (In years last birthday) yrs. <b>1</b>	IF UNDER 1 YEAR Months Days Hours Mins. <b>1 19 29</b>	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Roy Lee Cornish</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Bell Beasley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Sarah Bell Beasley - Cambridge Md. Route # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> <b>776 x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>(Maternal Cause Unknown)</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>43 hrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>12-4</b> , 19 <b>59</b> , to <b>12-5</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12-5</b> , 19 <b>59</b> , and that death occurred at <b>9:45 P.M.</b> , from the causes and on the date stated above.							
ACTUAL PHYSICIAN <b>Eldridge H. Wolff</b> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <b>Cambridge, Maryland 12-6-59</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Eldridge H. Wolff</b>				15 Locust Street - Cambridge, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/6/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Roy Lee Cornish</b>				ADDRESS <b>Harlock, Md</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 9 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2067167XVI



13048

CERTIFICATE OF DEATH

13048

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

Page One

1. NAME OF DECEASED MRS. J. M. [illegible]		2. SEX F		3. AGE [illegible]	
4. PLACE OF BIRTH [illegible]		5. DATE OF BIRTH [illegible]		6. PLACE OF DEATH [illegible]	
7. CAUSE OF DEATH [illegible]		8. MANNER OF DEATH [illegible]		9. TIME OF DEATH [illegible]	
10. SIGNATURE OF PHYSICIAN [illegible]		11. SIGNATURE OF REGISTRAR [illegible]		12. SIGNATURE OF WITNESSES [illegible]	
13. SIGNATURE OF DECEASED [illegible]		14. SIGNATURE OF NEXT OF KIN [illegible]		15. SIGNATURE OF BURIAL OFFICIAL [illegible]	
16. SIGNATURE OF MINISTER OF THE GOSPEL [illegible]		17. SIGNATURE OF CHURCH CLERK [illegible]		18. SIGNATURE OF FUNERAL HOME [illegible]	
19. SIGNATURE OF CEMETERY [illegible]		20. SIGNATURE OF INTERVIEWER [illegible]		21. SIGNATURE OF SUPERVISOR [illegible]	
22. SIGNATURE OF ASSISTANT SUPERVISOR [illegible]		23. SIGNATURE OF CLERK [illegible]		24. SIGNATURE OF RECORDER [illegible]	
25. SIGNATURE OF INDEXER [illegible]		26. SIGNATURE OF FILE CLERK [illegible]		27. SIGNATURE OF DISTRIBUTOR [illegible]	
28. SIGNATURE OF MAIL CLERK [illegible]		29. SIGNATURE OF TELETYPE CLERK [illegible]		30. SIGNATURE OF TELEPHONE CLERK [illegible]	
31. SIGNATURE OF STENOGRAPHER [illegible]		32. SIGNATURE OF TYPESETTER [illegible]		33. SIGNATURE OF PRINTER [illegible]	
34. SIGNATURE OF BINDER [illegible]		35. SIGNATURE OF FOLDER [illegible]		36. SIGNATURE OF LABELER [illegible]	
37. SIGNATURE OF INDEXER [illegible]		38. SIGNATURE OF FILE CLERK [illegible]		39. SIGNATURE OF DISTRIBUTOR [illegible]	
40. SIGNATURE OF MAIL CLERK [illegible]		41. SIGNATURE OF TELETYPE CLERK [illegible]		42. SIGNATURE OF TELEPHONE CLERK [illegible]	
43. SIGNATURE OF STENOGRAPHER [illegible]		44. SIGNATURE OF TYPESETTER [illegible]		45. SIGNATURE OF PRINTER [illegible]	
46. SIGNATURE OF BINDER [illegible]		47. SIGNATURE OF FOLDER [illegible]		48. SIGNATURE OF LABELER [illegible]	
49. SIGNATURE OF INDEXER [illegible]		50. SIGNATURE OF FILE CLERK [illegible]		51. SIGNATURE OF DISTRIBUTOR [illegible]	
52. SIGNATURE OF MAIL CLERK [illegible]		53. SIGNATURE OF TELETYPE CLERK [illegible]		54. SIGNATURE OF TELEPHONE CLERK [illegible]	
55. SIGNATURE OF STENOGRAPHER [illegible]		56. SIGNATURE OF TYPESETTER [illegible]		57. SIGNATURE OF PRINTER [illegible]	
58. SIGNATURE OF BINDER [illegible]		59. SIGNATURE OF FOLDER [illegible]		60. SIGNATURE OF LABELER [illegible]	
61. SIGNATURE OF INDEXER [illegible]		62. SIGNATURE OF FILE CLERK [illegible]		63. SIGNATURE OF DISTRIBUTOR [illegible]	
64. SIGNATURE OF MAIL CLERK [illegible]		65. SIGNATURE OF TELETYPE CLERK [illegible]		66. SIGNATURE OF TELEPHONE CLERK [illegible]	
67. SIGNATURE OF STENOGRAPHER [illegible]		68. SIGNATURE OF TYPESETTER [illegible]		69. SIGNATURE OF PRINTER [illegible]	
70. SIGNATURE OF BINDER [illegible]		71. SIGNATURE OF FOLDER [illegible]		72. SIGNATURE OF LABELER [illegible]	
73. SIGNATURE OF INDEXER [illegible]		74. SIGNATURE OF FILE CLERK [illegible]		75. SIGNATURE OF DISTRIBUTOR [illegible]	
76. SIGNATURE OF MAIL CLERK [illegible]		77. SIGNATURE OF TELETYPE CLERK [illegible]		78. SIGNATURE OF TELEPHONE CLERK [illegible]	
79. SIGNATURE OF STENOGRAPHER [illegible]		80. SIGNATURE OF TYPESETTER [illegible]		81. SIGNATURE OF PRINTER [illegible]	
82. SIGNATURE OF BINDER [illegible]		83. SIGNATURE OF FOLDER [illegible]		84. SIGNATURE OF LABELER [illegible]	
85. SIGNATURE OF INDEXER [illegible]		86. SIGNATURE OF FILE CLERK [illegible]		87. SIGNATURE OF DISTRIBUTOR [illegible]	
88. SIGNATURE OF MAIL CLERK [illegible]		89. SIGNATURE OF TELETYPE CLERK [illegible]		90. SIGNATURE OF TELEPHONE CLERK [illegible]	
91. SIGNATURE OF STENOGRAPHER [illegible]		92. SIGNATURE OF TYPESETTER [illegible]		93. SIGNATURE OF PRINTER [illegible]	
94. SIGNATURE OF BINDER [illegible]		95. SIGNATURE OF FOLDER [illegible]		96. SIGNATURE OF LABELER [illegible]	
97. SIGNATURE OF INDEXER [illegible]		98. SIGNATURE OF FILE CLERK [illegible]		99. SIGNATURE OF DISTRIBUTOR [illegible]	
100. SIGNATURE OF MAIL CLERK [illegible]		101. SIGNATURE OF TELETYPE CLERK [illegible]		102. SIGNATURE OF TELEPHONE CLERK [illegible]	

*Handwritten signature: J. M. [illegible]*

*Handwritten signature: [illegible]*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13661

CERTIFICATE OF DEATH

Reg. Dist. No.

13641

1. PLACE OF DEATH o. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>			c. LENGTH OF STAY IN 1b <b>2 weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glasgow Nursing Home</b>				d. STREET ADDRESS <b>108 N. Higgins</b>		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MAY</b> Middle <b>N.</b> Last <b>BRINSFIELD</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>11</b> Year <b>19 59</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 19, 1880</b>		9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>William B. Newnam</b>				14. MOTHER'S MAIDEN NAME <b>Edith Parsons</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. William Brinsfield</b> Address <b>Cordova, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis, progressive</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerosis generaliz</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pneumonia, lower lobe, hemorrhagic</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/9/53</b> , 19 <b>53</b> , to <b>12/11</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>12/10/53</b> , 19 <b>53</b> , and that death occurred at <b>10:30 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. B. Thompson</b> M.D.				ADDRESS (Street, city or town, state) <b>Cambridge, Md.</b> DATE SIGNED <b>Dec 13, 53</b>			
PHYSICIAN'S NAME (Type) <b>Dr. W. B. Thompson</b>				6 Locust St. Cambridge, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>Dec. 14, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Easton, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Maurice E. Newnam &amp; Son</b>				ADDRESS <b>Easton, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 16 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Adeline S. Thomas</b>			

Robert Robinson & Sons  
Limited  
London & Glasgow

Therese von der Linde

31/01/11

5/1/51

11/51

52

Chapman

John W. Brown

104 10706



CERTIFICATE OF DEATH

13642

Reg. Dist. No.

13662

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMPBRIDGE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxford</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CAMPBRIDGE HOSP.</u>		d. STREET ADDRESS <u>Box 191</u>	
3. NAME OF DECEASED (Type or print) <u>Gertrude</u> (Gertrude) Middle <u>2.</u> Last <u>Chase</u>		4. DATE OF DEATH Month <u>12</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/12/85</u>
9. AGE (In years last birthday) <u>74 1/2</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>12</u> Hours <u>12</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph H. Zeeen</u>		14. MOTHER'S MAIDEN NAME <u>Priscilla Payne</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>217-36-8438</u>	
17. INFORMANT Address <u>Joseph Chase, Oxford</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November</u> , 19 <u>57</u> , to <u>December</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>December 1</u> , 19 <u>59</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>227 Pine St-Camb., Md.</u> DATE SIGNED <u>12-3-59</u>	
PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/5/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Richards Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Easton Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Easton, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 10 59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanks</u>	

CERTIFICATE OF DEATH

1. PLACE OF DEATH  
2. DATE OF DEATH  
3. TIME OF DEATH  
4. SEX  
5. AGE  
6. OCCUPATION  
7. MARITAL STATUS  
8. PLACE OF BIRTH  
9. DATE OF BIRTH  
10. CAUSE OF DEATH  
11. MANNER OF DEATH  
12. SIGNATURE OF PHYSICIAN  
13. SIGNATURE OF REGISTRAR  
14. SIGNATURE OF WITNESSES  
15. SIGNATURE OF DECEASED  
16. SIGNATURE OF NEXT OF KIN  
17. SIGNATURE OF CLERGYMAN  
18. SIGNATURE OF MINISTER  
19. SIGNATURE OF CHURCH  
20. SIGNATURE OF FUNERAL HOME  
21. SIGNATURE OF BURIAL PLACE  
22. SIGNATURE OF CREMATOR  
23. SIGNATURE OF INTERMENT PLACE  
24. SIGNATURE OF INTERMENT DATE  
25. SIGNATURE OF INTERMENT TIME  
26. SIGNATURE OF INTERMENT LOCATION  
27. SIGNATURE OF INTERMENT METHOD  
28. SIGNATURE OF INTERMENT COST  
29. SIGNATURE OF INTERMENT TYPE  
30. SIGNATURE OF INTERMENT GRAVE  
31. SIGNATURE OF INTERMENT MONUMENT  
32. SIGNATURE OF INTERMENT PLANTING  
33. SIGNATURE OF INTERMENT FLOWERS  
34. SIGNATURE OF INTERMENT MUSIC  
35. SIGNATURE OF INTERMENT PRAYER  
36. SIGNATURE OF INTERMENT SONG  
37. SIGNATURE OF INTERMENT SCRIPTURE  
38. SIGNATURE OF INTERMENT BLESSING  
39. SIGNATURE OF INTERMENT COMMENDATION  
40. SIGNATURE OF INTERMENT RECOMMENDATION  
41. SIGNATURE OF INTERMENT PRAYER  
42. SIGNATURE OF INTERMENT SONG  
43. SIGNATURE OF INTERMENT SCRIPTURE  
44. SIGNATURE OF INTERMENT BLESSING  
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81. SIGNATURE OF INTERMENT COMMENDATION  
82. SIGNATURE OF INTERMENT RECOMMENDATION  
83. SIGNATURE OF INTERMENT PRAYER  
84. SIGNATURE OF INTERMENT SONG  
85. SIGNATURE OF INTERMENT SCRIPTURE  
86. SIGNATURE OF INTERMENT BLESSING  
87. SIGNATURE OF INTERMENT COMMENDATION  
88. SIGNATURE OF INTERMENT RECOMMENDATION  
89. SIGNATURE OF INTERMENT PRAYER  
90. SIGNATURE OF INTERMENT SONG  
91. SIGNATURE OF INTERMENT SCRIPTURE  
92. SIGNATURE OF INTERMENT BLESSING  
93. SIGNATURE OF INTERMENT COMMENDATION  
94. SIGNATURE OF INTERMENT RECOMMENDATION  
95. SIGNATURE OF INTERMENT PRAYER  
96. SIGNATURE OF INTERMENT SONG  
97. SIGNATURE OF INTERMENT SCRIPTURE  
98. SIGNATURE OF INTERMENT BLESSING  
99. SIGNATURE OF INTERMENT COMMENDATION  
100. SIGNATURE OF INTERMENT RECOMMENDATION

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13676

## CERTIFICATE OF DEATH

Reg. Dist. No. **14359**

<b>1. PLACE OF DEATH</b> o. COUNTY <u>Dorchester</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Cambridge</u>			c. LENGTH OF STAY IN 1b <u>Life</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Cambridge</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>RFD #1</u>				d. STREET ADDRESS <u>RFD #1</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Bertha G. Cummings</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>Dec 29 1959</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 29, 1886</u>		9. AGE (In years last birthday) yrs. <u>73</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Alexander Plater</u>				14. MOTHER'S MAIDEN NAME <u>Luisa J. Keene</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT Address <u>Robert Cummings, RFD #1, Cambridge, Md.</u>						
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>June</u> , 19 <u>59</u> , to <u>Dec 29</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>December 29</u> , 19 <u>59</u> , and that death occurred at <u>7 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>227 Pine St-Cambridge, Md.</u> DATE SIGNED <u>1-2-60</u> ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>J. Edwin Fassett, M.D.</u> PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>1/3/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Old Field Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>Dorchester Co., Md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Cambridge, Md.</u>					24a. REC'D BY REGISTRAR DATE <u>JAN 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14360

13663

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md.</u>				c. LENGTH OF STAY IN 1b <u>1 Week</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakesville, Maryland.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge, Md. Hospital.</u>				/ d. STREET ADDRESS <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sangston</u> Middle <u>G.</u> Last <u>Dixon</u>				4. DATE OF DEATH Month <u>12</u> Day <u>24</u> Year <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/19/1902</u>		9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plant Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sea Food Plant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Dixon</u>				14. MOTHER'S MAIDEN NAME <u>Annie Dixon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Le Compte Funeral Service, Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of urinary bladder</u> <u>181.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>with metastases</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>1 year(?)</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 5, 1958</u> , to <u>Dec 24, 1959</u> , that I last saw the deceased alive on <u>Dec 24</u> , 19 <u>59</u> , and that death occurred at <u>1:50 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1 Locust St.</u> DATE SIGNED ACTUAL SIGNATURE <u>Lewis M. Burdette</u> M.D. PHYSICIAN'S NAME (Type) <u>Lewis M. Burdette</u> <u>Cambridge, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/27/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park.</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Circling S. Knead</u>	



CERTIFICATE OF DEATH

1963

<p>1. NAME OF DECEASED                  [Handwritten: <i>John Doe</i>]</p>		<p>2. SEX                  [Handwritten: <i>Male</i>]</p>	
<p>3. AGE                  [Handwritten: <i>45</i>]</p>		<p>4. DATE OF BIRTH                  [Handwritten: <i>10/15/1918</i>]</p>	
<p>5. PLACE OF BIRTH                  [Handwritten: <i>Baltimore, Md.</i>]</p>		<p>6. OCCUPATION                  [Handwritten: <i>Teacher</i>]</p>	
<p>7. MARITAL STATUS                  [Handwritten: <i>Married</i>]</p>		<p>8. DATE OF MARRIAGE                  [Handwritten: <i>05/10/1940</i>]</p>	
<p>9. NAME OF SPOUSE                  [Handwritten: <i>Jane Doe</i>]</p>		<p>10. DATE OF DEATH                  [Handwritten: <i>11/01/1963</i>]</p>	
<p>11. PLACE OF DEATH                  [Handwritten: <i>Home</i>]</p>		<p>12. CAUSE OF DEATH                  [Handwritten: <i>Heart Disease</i>]</p>	
<p>13. MEDICAL HISTORY                  [Handwritten: <i>None</i>]</p>		<p>14. SIGNATURE OF PHYSICIAN                  [Handwritten: <i>Dr. J. Smith</i>]</p>	
<p>15. SIGNATURE OF REGISTRAR                  [Handwritten: <i>John Doe</i>]</p>		<p>16. SIGNATURE OF WITNESS                  [Handwritten: <i>John Doe</i>]</p>	

1  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 Item 1 Film G253 12-16-59 et  
 13677  
 CERTIFICATE OF DEATH

Reg. Dist. No.

13643

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Cambridge</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> 2212-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Ellen</b> Last <b>Ennis</b>				4. DATE OF DEATH Month <b>Dec</b> Day <b>5</b> Year <b>1959</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 28 1874</b>	
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months <b>85</b> Days <b>85</b> Hours <b>85</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Md. (Wico. County, Md)</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			
13. FATHER'S NAME <b>Joseph Maddex</b>				14. MOTHER'S MAIDEN NAME <b>Martha Shockley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>(Hospital records)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of Tongue</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>141.9</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>Unk</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Salisbury</b>				20g. (County) <b>Wicomico</b>			
20h. (State) <b>Md.</b>				20i. (Country) <b>USA</b>			
21. I certify that I attended the deceased from <b>Nov 2</b> , 19 <b>59</b> , to <b>Dec 5</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Dec 5</b> , 19 <b>59</b> , and that death occurred at <b>4:20 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>E.S.S. Hospital, Cambridge, Md. 12-5-59</b>							
ACTUAL SIGNATURE <b>Thomas J. Dredge</b>				DATE SIGNED <b>DEC 8 '59</b>			
PHYSICIAN'S NAME (Type) <b>Thomas J. Dredge</b>				DATE SIGNED <b>DEC 8 '59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Dec 8-1959</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>				22d. LOCATION (City, town, or county) <b>Salisbury, Md.</b>			
22e. (State) <b>Md.</b>				22f. (Country) <b>USA</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Hines</b>				23a. REC'D BY REGISTRAR DATE <b>DEC 8 '59</b>			
23b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>				23c. (City, town, or county) <b>Salisbury, Md.</b>			
23d. (State) <b>Md.</b>				23e. (Country) <b>USA</b>			

14881

U.S. DEPT. OF COMMERCE

1931

*[Faint, mostly illegible text, likely a form or report, with some visible words such as "U.S. DEPT. OF COMMERCE", "1931", and "U.S. DEPT. OF COMMERCE"]*

③

## CERTIFICATE OF DEATH

Reg. Dist. No.

14380

13664

1. PLACE OF DEATH o. COUNTY <u>Dorchester Co.</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East New Market, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge, Maryland Hospital</u>				d. STREET ADDRESS <u>None</u>			
3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>S.</u> Last <u>Harvey</u>				4. DATE OF DEATH Month <u>1</u> Day <u>2</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/7/1876</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Storr</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>Unknown</u>				17. INFORMANT <u>Mrs Leonard Cannon, Choptank Ave., Cambridge Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hemiplegia, right</u> DUE TO (c) <u>Arteriosclerosis, generalized</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>4 days</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. -- -- 19 p. m. -- --				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -- --	
20f. (City or town) (County) (State) -- --				21. I certify that I attended the deceased from <u>12-2-59</u> , 19 <u>  </u> , to <u>12-27-59</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>12-27-59</u> , 19 <u>  </u> , and that death occurred at <u>11:15PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Eldridge H. Wolff</u>				ADDRESS (Street, city or town, state) <u>15 Locust Street, Cambridge, Md.</u>			
DATE SIGNED <u>12-28-59</u>				22. PHYSICIAN'S NAME (Type) <u>Eldridge H. Wolff, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/30/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>East New Market Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>East New Market, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compt</u>				ADDRESS <u>Funeral Service, Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 11 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kiana</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  [REDACTED]</p>		<p>2. SEX                  [REDACTED]</p>	
<p>3. AGE                  [REDACTED]</p>		<p>4. DATE OF BIRTH                  [REDACTED]</p>	
<p>5. PLACE OF BIRTH                  [REDACTED]</p>		<p>6. OCCUPATION                  [REDACTED]</p>	
<p>7. MARITAL STATUS                  [REDACTED]</p>		<p>8. CAUSE OF DEATH                  [REDACTED]</p>	
<p>9. MEDICAL HISTORY                  [REDACTED]</p>		<p>10. DATE OF DEATH                  [REDACTED]</p>	
<p>11. PLACE OF DEATH                  [REDACTED]</p>		<p>12. SIGNATURE OF DECEASED                  [REDACTED]</p>	
<p>13. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>14. SIGNATURE OF PHYSICIAN                  [REDACTED]</p>	
<p>15. SIGNATURE OF CORONER                  [REDACTED]</p>		<p>16. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>17. SIGNATURE OF JURY                  [REDACTED]</p>		<p>18. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>19. SIGNATURE OF JURY                  [REDACTED]</p>		<p>20. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>21. SIGNATURE OF JURY                  [REDACTED]</p>		<p>22. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>23. SIGNATURE OF JURY                  [REDACTED]</p>		<p>24. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>25. SIGNATURE OF JURY                  [REDACTED]</p>		<p>26. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>27. SIGNATURE OF JURY                  [REDACTED]</p>		<p>28. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>29. SIGNATURE OF JURY                  [REDACTED]</p>		<p>30. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>31. SIGNATURE OF JURY                  [REDACTED]</p>		<p>32. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>33. SIGNATURE OF JURY                  [REDACTED]</p>		<p>34. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>35. SIGNATURE OF JURY                  [REDACTED]</p>		<p>36. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>37. SIGNATURE OF JURY                  [REDACTED]</p>		<p>38. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>39. SIGNATURE OF JURY                  [REDACTED]</p>		<p>40. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>41. SIGNATURE OF JURY                  [REDACTED]</p>		<p>42. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>43. SIGNATURE OF JURY                  [REDACTED]</p>		<p>44. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>45. SIGNATURE OF JURY                  [REDACTED]</p>		<p>46. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>47. SIGNATURE OF JURY                  [REDACTED]</p>		<p>48. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>49. SIGNATURE OF JURY                  [REDACTED]</p>		<p>50. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>51. SIGNATURE OF JURY                  [REDACTED]</p>		<p>52. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>53. SIGNATURE OF JURY                  [REDACTED]</p>		<p>54. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>55. SIGNATURE OF JURY                  [REDACTED]</p>		<p>56. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>57. SIGNATURE OF JURY                  [REDACTED]</p>		<p>58. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>59. SIGNATURE OF JURY                  [REDACTED]</p>		<p>60. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>61. SIGNATURE OF JURY                  [REDACTED]</p>		<p>62. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>63. SIGNATURE OF JURY                  [REDACTED]</p>		<p>64. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>65. SIGNATURE OF JURY                  [REDACTED]</p>		<p>66. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>67. SIGNATURE OF JURY                  [REDACTED]</p>		<p>68. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>69. SIGNATURE OF JURY                  [REDACTED]</p>		<p>70. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>71. SIGNATURE OF JURY                  [REDACTED]</p>		<p>72. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>73. SIGNATURE OF JURY                  [REDACTED]</p>		<p>74. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>75. SIGNATURE OF JURY                  [REDACTED]</p>		<p>76. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>77. SIGNATURE OF JURY                  [REDACTED]</p>		<p>78. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>79. SIGNATURE OF JURY                  [REDACTED]</p>		<p>80. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>81. SIGNATURE OF JURY                  [REDACTED]</p>		<p>82. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>83. SIGNATURE OF JURY                  [REDACTED]</p>		<p>84. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>85. SIGNATURE OF JURY                  [REDACTED]</p>		<p>86. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>87. SIGNATURE OF JURY                  [REDACTED]</p>		<p>88. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>89. SIGNATURE OF JURY                  [REDACTED]</p>		<p>90. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>91. SIGNATURE OF JURY                  [REDACTED]</p>		<p>92. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>93. SIGNATURE OF JURY                  [REDACTED]</p>		<p>94. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>95. SIGNATURE OF JURY                  [REDACTED]</p>		<p>96. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>97. SIGNATURE OF JURY                  [REDACTED]</p>		<p>98. SIGNATURE OF JURY                  [REDACTED]</p>	
<p>99. SIGNATURE OF JURY                  [REDACTED]</p>		<p>100. SIGNATURE OF JURY                  [REDACTED]</p>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13665

CERTIFICATE OF DEATH

Reg. Dist. No.

13645

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>Few hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taylor's Island</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Cambridge Maryland Hospital</u>				/d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>J.</u> Last <u>Henson</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>3</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 30, 1886</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>19</u> Hours <u>59</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>	
11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Robert J. Henson</u>			
14. MOTHER'S MAIDEN NAME <u>Sophia Keene</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Josephine Henson, Taylor's Island, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSION</u> DUE TO (c) <u>-----</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 HOURS</u> <u>10 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Cambridge</u>				20g. (County) <u>Dorchester Co.</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>6/9/55</u> to <u>12/3/59</u> , that I last saw the deceased alive on <u>12/2/59</u> , and that death occurred at <u>3 A</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W.E. GUNBY JR</u>				ADDRESS (Street, city or town, state) <u>105 CHURCH ST. CAMBRIDGE MD.</u>			
DATE SIGNED <u>4 DEC 59</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/6/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Smithville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Dorchester Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert M. Seligson Jr</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

28067

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13646

13678

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>				c. LENGTH OF STAY IN 1b <u>18 MONTHS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTERN SHORE STATE HOSPITAL</u>				d. STREET ADDRESS <u>20 X - 2</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>ROBERT</u> First <u>EMMETT</u> Middle <u>JACKSON</u> Last				4. DATE OF DEATH Month <u>DEC.</u> Day <u>5</u> Year <u>1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-18-78</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>MARTIN T. JACKSON</u>				14. MOTHER'S MAIDEN NAME <u>PERCELY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u>				16. SOCIAL SECURITY NO. <u>213-12-5707</u>			
INFORMANT <u>HOSPITAL RECORDS</u>				Address			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERAL ARTERIOSCLEROSIS</u> DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>MAY 17, 1958</u> to <u>DEC. 4, 1959</u> , that I last saw the deceased alive on <u>DEC. 4, 1959</u> , and that death occurred at <u>2:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ettore DeFilippis</u>				ADDRESS (Street, city or town, state) <u>Eastern Shore State Hospital</u> DATE SIGNED _____			
PHYSICIAN'S NAME (Type) <u>ETTORE DEFILIPPIS</u>				<u>CAMBRIDGE, MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec. 8, 1959</u>		<u>Christ Cemetery</u>		<u>St. Michaels</u> <u>md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuelton Harrison</u>				ADDRESS <u>St. Michaels</u>			
24a. REC'D BY REGISTRAR <u>DEC 8 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			

CERTIFICATE OF DEATH

1980

1

DORCHESTER

CAMPBELL

SPRING

ST. ALBANS

ALL INFORMATION TO BE FURNISHED TO THE

ROBERT EMMETT JACKSON

DEC. 2

ALICE WHITE

3-10-18

XX

MARTIN T JACKSON

MAY 1918

RECEIVED

MARTIN T JACKSON

NOT FURTHER RECORDS

NO 12-18

1918

ALL INFORMATION TO BE FURNISHED TO THE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13666

## CERTIFICATE OF DEATH

14361

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>427 High Street</u>		d. STREET ADDRESS <u>427 High Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lillie</u> Middle <u>B.</u> Last <u>Jolley</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>21</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 26, 1878</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Caroline County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Adams</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Cannon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Edyth M. Jolley, Cambridge, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December 15, 1959</u> , to <u>Dec 21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>December 21</u> , 19 <u>59</u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>227 Pine St-Cambridge, Md.</u> DATE SIGNED <u>12-26-59</u> ACTUAL SIGNATURE <u>J. Edwin Fassett</u> M.D. PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/27/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Salem Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Dorchester County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert M. Hollands</u>		ADDRESS <u>Cambridge, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JAN 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1-30-01

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>		<p>9. PLACE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. SIGNATURE OF WITNESSES</p>		<p>14. SIGNATURE OF DECEASED</p>		<p>15. SIGNATURE OF NEXT OF KIN</p>		<p>16. SIGNATURE OF CLERGYMAN</p>		<p>17. SIGNATURE OF JUDGE</p>		<p>18. SIGNATURE OF SHERIFF</p>	
<p>19. SIGNATURE OF CORONER</p>		<p>20. SIGNATURE OF JURY</p>		<p>21. SIGNATURE OF DISTRICT ATTORNEY</p>		<p>22. SIGNATURE OF COUNTY CLERK</p>		<p>23. SIGNATURE OF TOWNSHIP CLERK</p>		<p>24. SIGNATURE OF VILLAGE CLERK</p>	
<p>25. SIGNATURE OF CITY CLERK</p>		<p>26. SIGNATURE OF STATE CLERK</p>		<p>27. SIGNATURE OF NATIONAL CLERK</p>		<p>28. SIGNATURE OF INTERNATIONAL CLERK</p>		<p>29. SIGNATURE OF UNITED NATIONS CLERK</p>		<p>30. SIGNATURE OF WORLD CLERK</p>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

13679

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock - Rural</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Near Elwood</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Gertrude</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>December</u> Day <u>31</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 15, 1870</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Lou Cephas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Spencer C. Jones, Hurlock, Maryland, R.F.D.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right Hemiplegia</u> DUE TO <u>334x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>25 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. <u>  </u> p. m. <u>  </u> Month <u>  </u> Day <u>  </u> Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1/15</u> , 19 <u>56</u> , to <u>12/31</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/25</u> , 19 <u>59</u> , and that death occurred at <u>11:30P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harold B. Primmer</u> M.D.				ADDRESS (Street, city or town, state) <u>Preston Maryland</u> DATE SIGNED <u>1/2/60</u>			
PHYSICIAN'S NAME (Type) <u>Harold B. Primmer</u>				<u>Preston Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 3, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Near Hurlock, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Prampton and Son, Federalburg, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

13647

13667

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>J. Hubbard</u>		d. STREET ADDRESS <u>3 Hubbard</u>	
3. NAME OF DECEASED (Type or print) <u>Sarah Elizabeth Jones</u>		4. DATE OF DEATH <u>12</u> Month <u>2</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 2</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Nathiel Chase</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Ann Roberts</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>	
16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>John Jones Cambridge, Md.</u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Urinary Bladder</u> <u>181.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Hour <u></u> o. m. <u></u> p. m. <u></u> Month <u></u> Day <u></u> Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) <u></u> (County) <u></u> (State) <u></u>
21. I certify that I attended the deceased from <u>December 19, 1958</u> , to <u>December 29, 1959</u> , that I last saw the deceased alive on <u>December 2, 1959</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>227 Pine St-Camb, Md</u> DATE SIGNED <u>12-3-59</u>	
PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>12/5/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Cambridge Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Easton, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 10 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**13680**  
**CERTIFICATE OF DEATH**

13648

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Toddville</b>		c. LENGTH OF STAY IN 1b <b>entire life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Toddville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rural</b>				d. STREET ADDRESS <b>Rural</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Flowers</b> Last <b>Jones</b>				4. DATE OF DEATH Month <b>December</b> Day <b>21</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 22, 1878</b>		9. AGE (In years last birthday) <b>81</b> yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Food Canner</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Toddville</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.</b>		
13. FATHER'S NAME <b>Thomas Jones</b>				14. MOTHER'S MAIDEN NAME <b>Adeline E. Ross</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>W. Paul Jones, Cambridge, MR.D.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>1 HOUR</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>1/15</b> 19 <b>58</b> to <b>21 DEC</b> 19 <b>59</b> , that I last saw the deceased alive on _____, 19____, and that death occurred at <b>4:00 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Walter E. Gunby Jr</i>		ADDRESS (Street, city or town, state) <b>Cambridge, Md.</b>				DATE SIGNED <b>23 Dec</b>	
PHYSICIAN'S NAME (Type) <b>WALTER E. GUNBY JR</b>		<b>MD.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 24, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Jones Family Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Toddville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kenneth R. Shover</i>				ADDRESS <b>Cambridge, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 28 '59</b>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 13668 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>3 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woolford</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Maryland Hospital</u>			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Gary</u> Middle <u>Levin</u> Last <u>Lee</u>			4. DATE OF DEATH Month <u>December</u> Day <u>7</u> Year <u>19 59</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 24, 1958</u>	9. AGE (In years last birthday) <u>1</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Levin Lee Jr.</u>			14. MOTHER'S MAIDEN NAME <u>Alice Robinson</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Levin Lee Jr. Woolford, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspirin poisoning</u> <u>872.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <u>Aspirin poisoning</u> DUE TO cause lost.					INTERVAL BETWEEN ONSET AND DEATH <u>Abt. 12 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was found playing with bottle of aspirin.</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>10:30</u> a. m. <u>AM</u> <u>12/7</u> <u>19 59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Woolford</u>	(County) <u>Dor.</u>	(State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>John Mace Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12/15/59</u>	
EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/8/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bethlehem Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bethlehem, Talbot, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert StClair</u>		ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 15 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

15068

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

15068 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX M		3. AGE 35		4. DATE OF BIRTH 12/1/29	
5. PLACE OF BIRTH MOBILE, ALA.		6. OCCUPATION CONGRESSMAN		7. MARITAL STATUS MARRIED		8. EDUCATION HIGH SCHOOL	
9. PRESENT ADDRESS 1111 17th St. N.W. WASHINGTON, D.C.		10. CAUSE OF DEATH HEART DISEASE		11. MANNER OF DEATH NATURAL		12. PLACE OF DEATH WASHINGTON, D.C.	
13. SIGNATURE OF EXAMINER J. Edgar Hoover		14. SIGNATURE OF DECEASED James Earl Ray		15. SIGNATURE OF WITNESS John Edgar Hoover		16. SIGNATURE OF WITNESS John Edgar Hoover	
17. SIGNATURE OF WITNESS John Edgar Hoover		18. SIGNATURE OF WITNESS John Edgar Hoover		19. SIGNATURE OF WITNESS John Edgar Hoover		20. SIGNATURE OF WITNESS John Edgar Hoover	
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97. SIGNATURE OF WITNESS John Edgar Hoover		98. SIGNATURE OF WITNESS John Edgar Hoover		99. SIGNATURE OF WITNESS John Edgar Hoover		100. SIGNATURE OF WITNESS John Edgar Hoover	

13669

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>30 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13 Cambridge</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>215 Maryland Ave.,</b>				d. STREET ADDRESS <b>215 Maryland Ave.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Henry</b> Last <b>Leonard, Jr.</b>				4. DATE OF DEATH Month <b>December</b> Day <b>15</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 15, 1900</b>		9. AGE (In years last birthday) <b>59</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Automobile Dealer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Cambridge</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William H. Leonard, Sr.,</b>				14. MOTHER'S MAIDEN NAME <b>Mattie Dean</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Mary Blanche Leonard, 215 Md. Ave., Cambridge</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-26-44</b> , 19____, to <b>12-15-59</b> , 19____, that I last saw the deceased alive on <b>12-15-59</b> , 19____, and that death occurred at <b>5:00 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Albert E. Bunker</i>		M.D. <b>200 Maryland Avenue</b>		ADDRESS (Street, city or town, state) <b>200 Maryland Avenue</b>		DATE SIGNED <b>11-16-59</b>	
PHYSICIAN'S NAME (Type) <b>ALBERT E. BUNKER, M. D.</b>		<b>Cambridge, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 17, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Green Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kenneth R. Howard</i>				ADDRESS <b>Cambridge, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 21 '59</b>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Howard</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13670

## CERTIFICATE OF DEATH

Reg. Dist. No.

13651

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>entire life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge-Maryland Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Robert Leon Lewis, Jr.</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>28</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 26, 1959</b>
9. AGE (In years last birthday) yrs. <b>3</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Cambridge</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Robert Leon Lewis, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Elsie Diane Holliday</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>209 W. Appleby Ave.,</b>	
17. INFORMANT <b>Robert. Leon Lewis, Sr., Cambridge, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> <b>754.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Causing Heart Failure</b> DUE TO (c) <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-26</b> , 19 <b>59</b> to <b>12-28</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>4:00 PM</b> , 19 <b>59</b> , and that death occurred at <b>4:00 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>[Signature]</b>		DATE SIGNED <b>12-29-59</b>	
PHYSICIAN'S NAME (Type) <b>[Signature]</b>		ADDRESS (Street, city or town, state) <b>Cambridge</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 29, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Green Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 5 '60</b>	
ADDRESS <b>Cambridge, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

# CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE 10

1900

<p>NAME OF DECEASED</p>		<p>AGE</p>	
<p>SEX</p>		<p>RACE</p>	
<p>DATE OF BIRTH</p>		<p>DATE OF DEATH</p>	
<p>PLACE OF BIRTH</p>		<p>PLACE OF DEATH</p>	
<p>CAUSE OF DEATH</p>		<p>IMMEDIATE CAUSE</p>	
<p>UNDERLYING CAUSE</p>		<p>PERMANENT CAUSE</p>	
<p>DATE OF EXAMINATION</p>		<p>TIME OF EXAMINATION</p>	
<p>NAME OF PHYSICIAN</p>		<p>NAME OF EXAMINER</p>	
<p>SIGNATURE OF PHYSICIAN</p>		<p>SIGNATURE OF EXAMINER</p>	
<p>DATE OF SIGNATURE</p>		<p>TIME OF SIGNATURE</p>	
<p>NAME OF REGISTRAR</p>		<p>NAME OF CLERK</p>	
<p>SIGNATURE OF REGISTRAR</p>		<p>SIGNATURE OF CLERK</p>	
<p>DATE OF SIGNATURE</p>		<p>TIME OF SIGNATURE</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13671

## CERTIFICATE OF DEATH

14364

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hurlock</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge-Maryland Hospital</b>		/d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Parker</b>		4. DATE OF DEATH Month Day Year <b>December 31 19 59</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-30-59</b>
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Min. <b>7 45</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Clarence Cephas</b>		14. MOTHER'S MAIDEN NAME <b>Lucille Mae Parker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Lucille Mae Parker</b>	
17. INFORMANT <b>Lucille Mae Parker</b>		Address <b>Hurlock, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>773.5</b> DUE TO <b>Internal hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>Premature (wt 1lb. 8oz)</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>8 hours</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-30-59</b> to <b>12-30-59</b> , that I last saw the deceased alive on <b>12-30-59</b> , and that death occurred at <b>4:20 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>227 Pine St. Cambridge, Maryland 1-3-60</b> ACTUAL SIGNATURE <b>Dr. J. Edwin Fassett</b> M.D. <b>Cambridge, Maryland</b> PHYSICIAN'S NAME (Type) <b>Dr. J. Edwin Fassett - 227 Pine Street, Cambridge, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>1-2-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cambridge Maryland Hospital</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR DATE <b>JAN 8 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>	

2067185XV0

CERTIFICATE OF DEATH

1901

1-302

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
JAMES J. JONES		Male		35		Jan 1, 1866		Baltimore, Md.	
6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF PHYSICIAN	
Clerk		Heart Disease		Home		10:30 AM		J. J. Jones	
11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES		13. SIGNATURE OF CLERK		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF DECEASED	
J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF DECEASED		18. SIGNATURE OF DECEASED		19. SIGNATURE OF DECEASED		20. SIGNATURE OF DECEASED	
J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF DECEASED		23. SIGNATURE OF DECEASED		24. SIGNATURE OF DECEASED		25. SIGNATURE OF DECEASED	
J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones	
26. SIGNATURE OF DECEASED		27. SIGNATURE OF DECEASED		28. SIGNATURE OF DECEASED		29. SIGNATURE OF DECEASED		30. SIGNATURE OF DECEASED	
J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF DECEASED		33. SIGNATURE OF DECEASED		34. SIGNATURE OF DECEASED		35. SIGNATURE OF DECEASED	
J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones	
36. SIGNATURE OF DECEASED		37. SIGNATURE OF DECEASED		38. SIGNATURE OF DECEASED		39. SIGNATURE OF DECEASED		40. SIGNATURE OF DECEASED	
J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF DECEASED		43. SIGNATURE OF DECEASED		44. SIGNATURE OF DECEASED		45. SIGNATURE OF DECEASED	
J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones	
46. SIGNATURE OF DECEASED		47. SIGNATURE OF DECEASED		48. SIGNATURE OF DECEASED		49. SIGNATURE OF DECEASED		50. SIGNATURE OF DECEASED	
J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones	
51. SIGNATURE OF DECEASED		52. SIGNATURE OF DECEASED		53. SIGNATURE OF DECEASED		54. SIGNATURE OF DECEASED		55. SIGNATURE OF DECEASED	
J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones	
56. SIGNATURE OF DECEASED		57. SIGNATURE OF DECEASED		58. SIGNATURE OF DECEASED		59. SIGNATURE OF DECEASED		60. SIGNATURE OF DECEASED	
J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF DECEASED		63. SIGNATURE OF DECEASED		64. SIGNATURE OF DECEASED		65. SIGNATURE OF DECEASED	
J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones	
66. SIGNATURE OF DECEASED		67. SIGNATURE OF DECEASED		68. SIGNATURE OF DECEASED		69. SIGNATURE OF DECEASED		70. SIGNATURE OF DECEASED	
J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones	
71. SIGNATURE OF DECEASED		72. SIGNATURE OF DECEASED		73. SIGNATURE OF DECEASED		74. SIGNATURE OF DECEASED		75. SIGNATURE OF DECEASED	
J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones	
76. SIGNATURE OF DECEASED		77. SIGNATURE OF DECEASED		78. SIGNATURE OF DECEASED		79. SIGNATURE OF DECEASED		80. SIGNATURE OF DECEASED	
J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF DECEASED		83. SIGNATURE OF DECEASED		84. SIGNATURE OF DECEASED		85. SIGNATURE OF DECEASED	
J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones	
86. SIGNATURE OF DECEASED		87. SIGNATURE OF DECEASED		88. SIGNATURE OF DECEASED		89. SIGNATURE OF DECEASED		90. SIGNATURE OF DECEASED	
J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF DECEASED		93. SIGNATURE OF DECEASED		94. SIGNATURE OF DECEASED		95. SIGNATURE OF DECEASED	
J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones	
96. SIGNATURE OF DECEASED		97. SIGNATURE OF DECEASED		98. SIGNATURE OF DECEASED		99. SIGNATURE OF DECEASED		100. SIGNATURE OF DECEASED	
J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones	

Cambridge, Maryland

1-3-10



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13681

CERTIFICATE OF DEATH

Reg. Dist. No.

13652

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Cambridge</b>		c. LENGTH OF STAY IN 1b <b>2 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JANIE</b> Middle <b>J.</b> Last <b>PARSONS</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>8</b> Year <b>1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/19/78</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Julius Jones</b>		14. MOTHER'S MAIDEN NAME <b>Elisa Payne</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>none</b>	
17. INFORMANT <b>Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b> 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile Psychosis</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 26</b> , 1957, to <b>Dec 8</b> , 1959, that I last saw the deceased alive on <b>Dec 8</b> , 1959, and that death occurred at <b>9:15 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>E.S.S. Hospital, Cambridge, Md.</b> DATE SIGNED <b>12-8-59</b>			
ACTUAL SIGNATURE <b>Thomas J. Dredge</b>		M.D. <b>E.S.S. Hospital, Cambridge, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Thomas J. Dredge</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-11-59</b>	
22c. NAME OF CEMETERY <b>Methodist Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Stockton, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry A. Watson</b>		ADDRESS <b>Pocomoke City, Md.</b>	
24a. REC'D BY REGISTRAR <b>DEC 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

1

1



# CERTIFICATE OF DEATH

13653

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rhodesdale - Rural</b>		c. LENGTH OF STAY IN lb <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rhodesdale - Rural</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Reid's Grove</b>				d. STREET ADDRESS <b>Reid's Grove</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Della</b> Middle <b>Mae</b> Last <b>Rideout</b>				4. DATE OF DEATH Month <b>December</b> Day <b>13</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 16, 1958</b>	9. AGE (In years last birthday) <b>1</b> yrs.	IF UNDER 1 YEAR Months <b>1</b> Days <b>13</b>	IF UNDER 24 HRS. Hours <b>13</b> Min. <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Leroy Rideout</b>			14. MOTHER'S MAIDEN NAME <b>Anna Davis</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Leroy Rideout, Rhodesdale, Maryland, RFD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-Pneumonia Bilateral</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>Dec 12, 1959</b> , to <b>Dec 12, 1959</b> , that I last saw the deceased alive on <b>Dec 12, 1959</b> , and that death occurred at <b>8:15 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. E. Lennon</b>				M.D. <b>Federalburg, Maryland</b>		DATE SIGNED <b>12-14-59</b>	
PHYSICIAN'S NAME (Type) <b>W. E. Lennon, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 14, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Reid's Grove Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Reid's Grove, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Frampton and Son, Federalburg, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

VS A15 (4)  
15M 10/57

CERTIFICATE OF DEATH

FILE NO. 100

10000

DEPT. OF HEALTH  
BALTIMORE  
JAN 10 1900  
RECEIVED

ARTHUR S. KRAUS, Sc.D.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13683

## CERTIFICATE OF DEATH

Reg. Dist. No.

13654

1. PLACE OF DEATH o. COUNTY <u>Norchester.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Wiconisco.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury.</u> 2212.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital.</u>				d. STREET ADDRESS <u>418. Forest Lane</u>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>HENRY</u> Last <u>SAVAGE.</u>				4. DATE OF DEATH Month <u>December</u> Day <u>24</u> Year <u>1959</u>			
5. SEX <u>Male.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/27/1894</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Salesman Eno. Steel Works</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia.</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>JOHN Savage.</u>				14. MOTHER'S MAIDEN NAME <u>Sara BUNCIN. Bunchief</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-10-6597</u>		17. INFORMANT <u>Eastern Shore State Hospital records.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis with C.V.</u> <u>441X</u> DUE TO <u>disease.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malignant Hypertension.</u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Psychosis with Cerebral Arteriosclerosis.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>March 7, 1952</u> to <u>Dec. 24, 1959</u> , that I last saw the deceased alive on <u>Dec. 24, 1959</u> , and that death occurred at <u>5:25 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Simon Vizkutti</u>				ADDRESS (Street, city or town, state) <u>E.S.S. Hospital, Cambridge Md.</u>			
PHYSICIAN'S NAME (Type) <u>Simon Vizkutti</u>				DATE SIGNED <u>12/24/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>Dec. 28-59</u>		<u>Parson Cem.</u>		<u>Salisbury Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hollong &amp; Co. Salisbury Md.</u>				ADDRESS <u>Salisbury Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 4 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 only should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13684

## CERTIFICATE OF DEATH

Reg. Dist. No.

13655

1. PLACE OF DEATH o. COUNTY <u>DORCHESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>		c. LENGTH OF STAY IN 1b <u>5 YRS. 4 MOS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTERN SHORE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSHUA BURTON SMACK</u>		4. DATE OF DEATH Month Day Year <u>DECEMBER 13 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>Single</u>	8. DATE OF BIRTH <u>MARCH 6 1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HELPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	9. AGE (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>MARYLAND (Wango)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>PETER S. SMACK</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Arvey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>PEARL SMACK</u>	
17. INFORMANT <u>Mrs. Stella Bozman (Sister)</u> Address <u>Salisbury, Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOBAR PNEUMONIA</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>EPILEPSY</u> DUE TO (c) <u>CORONARY OCCLUSION</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>12 HOURS</u> <u>53 YEARS</u> <u>4 HOURS</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>APRIL 25, 1957</u> , to <u>DEC. 13, 1959</u> , that I last saw the deceased alive on <u>DECEMBER 12 1959</u> , and that death occurred at <u>4:00 A.M.</u> , from the causes and on the date stated above.	
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>Harry J. Crawford</u>		M.D. <u>EASTERN SHORE STATE HOSP - CAMBRIDGE</u> <u>DEC 13 1959</u>	
PHYSICIAN'S NAME (Type) <u>HARRY J. CRAWFORD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 15, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery-R.D.# Powellville, Maryland</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR <u>DEC 17 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

48501

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13672

## CERTIFICATE OF DEATH

Reg. Dist. No.

13656

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester Co.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md.</u>		c. LENGTH OF STAY IN 1b <u>2 Month</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wingate, Md.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>207, W. Appleby</u>			d. STREET ADDRESS <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Lester</u> Middle <u>O.</u> Last <u>Thomas</u>			4. DATE OF DEATH Month <u>12</u> Day <u>5</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/11/1885</u>		9. AGE (In years last birthday) <u>74</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Barber</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>William E. Thomas</u>			14. MOTHER'S MAIDEN NAME <u>Mary Todd</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Netha Thomas, Wingate, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332x Medullary paralysis, progressive</u>					<u>2 mos</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral thromboses, progressive</u>					<u>2 mos</u>
(c) <u>Arterio-sclerosis, generalized</u>					<u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Residual Lt. hemiplegia see to above</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>Oct 5, 1959</u> , to <u>Dec 5, 1959</u> , that I last saw the deceased alive on <u>Dec 5, 1959</u> , and that death occurred at <u>Wingate, Md.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>Cambridge, Md.</u> DATE SIGNED <u>12/7/59</u>			
PHYSICIAN'S NAME (Type) <u>[Signature]</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/7/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem., Park.</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Md.</u>			24a. REC'D BY REGISTRAR DATE <u>DEC 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

35251

2000

111. *Chrysomelidae* *Chrysomelidae*  
 112. *Chrysomelidae* *Chrysomelidae*  
 113. *Chrysomelidae* *Chrysomelidae*

Handwritten text: "Handwritten at Washington on the 10th of Nov."

*[Faint handwritten notes at the bottom of the page, possibly "Page 2" or similar.]*

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kingston</b> 19X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>		d. STREET ADDRESS --	
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Theodore</b> Last <b>Turpin</b>		4. DATE OF DEATH Month <b>December</b> Day <b>23</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-28-84</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Storekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Alfred B. Turpin</b>	
14. MOTHER'S MAIDEN NAME <b>Elizabeth Bell Turpin</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --	
16. SOCIAL SECURITY NO. --		17. INFORMANT <b>Eastern Shore State Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>Sev. yrs.</b>  <b>10 yrs. plus</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>12-19</b> , 19 <b>59</b> , to <b>12-23</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12-23-</b> , 19 <b>59</b> , and that death occurred at <b>7:30a</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>George E. Currier</i>		M.D.	
PHYSICIAN'S NAME (Type) <b>George E. Currier, M.D.</b>		<b>E.S.S. Hospital, Cambridge, Md. 12-23-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>12/26/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Marion Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Harvey Bradshaw</b>		ADDRESS <b>Crusfield Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>DEC 29 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13686 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13659

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Somerset</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>	c. LENGTH OF STAY IN 1b <b>30 years</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b> <b>1939-2</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>E.S.S. Hospital</b>		d. STREET ADDRESS <b>?</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Ruby</b> Middle <b>Roach</b> Last <b>Tymerson</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>5</b> Year <b>19 59</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/26/94</b>
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <del>William Roach</del> <b>William Roach</b>		14. MOTHER'S MAIDEN NAME <del>Elizabeth Lawson</del> <b>Elizabeth Lawson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Records E.S.S. Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) <b>John Mace Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>12/5/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>DEC. 8, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ROACH CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>CRISFIELD MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>BRADSHAW &amp; SONS</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 9 '59</b>	
ADDRESS <b>CRISFIELD, MD.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kenna</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13661

13673

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dorchester Co.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Tubunan Apts.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Erik Townsend Windsor</u>			4. DATE OF DEATH Month Day Year <u>12 11 19 59</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/28/1959</u>		9. AGE (In years last birthday) <u>30</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ronald Windson</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Townsend</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>Mr Ronald Windsor, Tubunan Apts. Cambridge, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>751x Congenital Hydrocephalus</u> DUE TO (b) <u>Congenital Cephalomeningocele</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>7 mos.</u> <u>7 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Other congenital anomalies chest &amp; abdomen</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4-28-</u> , 19 <u>59</u> , to <u>12-11-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12-11</u> , 19 <u>59</u> , and that death occurred at <u>10:20</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cambridge</u> DATE SIGNED <u>12-12-59</u>							
ACTUAL SIGNATURE <u>W. Bannan</u> M.D.							
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/12/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park.</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Maryland.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 29 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13687

## CERTIFICATE OF DEATH

13660

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Wicomico.</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury.</u> <u>2212-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>James</u> <u>UPSHUR</u> <u>Warwick</u>			4. DATE OF DEATH Month Day Year <u>Dec.</u> <u>19</u> <u>1959.</u>				
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/25/1875.</u>	9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOHN WARWICK.</u>				14. MOTHER'S MAIDEN NAME <u>Francis Parker.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>No.</u>		17. INFORMANT <u>Hospital records.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis.</u> <u>156.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cancer of the liver.</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>sever yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>senile PSYCHOSIS.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/2</u> , 19 <u>59</u> , to <u>Dec. 19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec. 19</u> , 19 <u>59</u> , and that death occurred at <u>4:50 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Simon Virkutis</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>E.S.S. H. Cambridge, Md.</u> <u>12/19/59.</u>			
PHYSICIAN'S NAME (Type) <u>Simon Virkutis.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/22/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Garson Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Newman</u> <u>Tom Pasquith</u>				ADDRESS <u>Theresa Lane</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 30 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **13662**

**13688**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Dorchester</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Dorchester</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge, R.D.</b>			c. LENGTH OF STAY IN 1b <b>6 weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge, R.D. 2</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge-Maryland Hospital</b>				d. STREET ADDRESS <b>Rural</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Anna Lucille</b> Middle <b>Woolford</b> Last				<b>4. DATE OF DEATH</b> Month <b>Dec. 13, 1959</b> Day <b>19</b> Year			
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Sept. 4, 1890</b>	
<b>9. AGE</b> (In years last birthday) <b>69 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Homemakers</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Centreville, Md. R.D.</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>							
<b>13. FATHER'S NAME</b> <b>Albert Greaves</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Minerva (last name unknown)</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <b>Mr. Calvin Woolford, Cambridge, Md.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <b>Pulmonary embolus</b> DUE TO <b>Fracture neck femur,</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>822X</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>5 Min.</b>  <b>6 wks.</b>
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input checked="" type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Was passenger in auto which overturned.</b>			
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>5 PM. 10/31 19 59</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Highway Nr. Marydel</b>		<b>20f. (City or town) (County) (State)</b> <b>Del.</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>							
<b>ACTUAL SIGNATURE</b>  <b>EXAMINER'S NAME (Type)</b> <b>Dr. John Mace Jr.</b>				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>12/15/59</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>Dec. 16, 1959</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Dorchester Memorial Park</b>		<b>22d. LOCATION (City, town, or county) (State)</b> <b>Cambridge, Md.</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b>  <b>ADDRESS</b> <b>Cambridge, Md.</b>				<b>24a. REC'D BY REGISTRAR</b> <b>DEC 18 '59</b>		<b>24b. REGISTRAR'S SIGNATURE</b> 	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13674

## CERTIFICATE OF DEATH

Reg. Dist. No.

13663

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. LENGTH OF STAY IN 1b <b>entire life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Maryland Ave</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Daniel</b> Middle <b>Henry</b> Last <b>Wright, Jr.</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>12</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 24, 1911</b>	9. AGE (In years last birthday) <b>48 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>State Employment Office Worker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Cambridge</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.</b>	
13. FATHER'S NAME <b>Daniel Henry Wright, Sr.,</b>				14. MOTHER'S MAIDEN NAME <b>Ruth Brown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>215-16-3006</b>			
17. INFORMANT <b>Mrs. Ida S. Wright, Maryland Ave., Cambridge, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>4 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>12-9</b> , 19 <b>59</b> , to <b>12-12</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12-12</b> , 19 <b>59</b> , and that death occurred at <b>10.50 P.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>G. W. Bannmann</b> M.D.				ADDRESS (Street, city or town, state) <b>Cambridge</b> DATE SIGNED <b>12-13-59</b>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 15, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth R. Thorne</b>				ADDRESS <b>Cambridge, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 18 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

MARYLAND STATE DEPARTMENT OF HEALTH  
1957  
CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. RACE <i>White</i>	
5. DATE OF BIRTH <i>Jan 15, 1912</i>		6. PLACE OF BIRTH <i>Baltimore, Md.</i>	
7. DATE OF DEATH <i>Dec 10, 1957</i>		8. PLACE OF DEATH <i>Home</i>	
9. TIME OF DEATH <i>10:30 AM</i>		10. CAUSE OF DEATH <i>Myocardial Infarction</i>	
11. MANNER OF DEATH <i>Natural</i>		12. SIGNATURE OF PHYSICIAN <i>Dr. J. K. Smith</i>	
13. SIGNATURE OF REGISTRAR <i>John Doe</i>		14. SIGNATURE OF WITNESSES <i>John Doe, Jane Doe</i>	
15. SIGNATURE OF FUNERAL HOME <i>John Doe</i>		16. SIGNATURE OF BURIAL PLACE <i>John Doe</i>	
17. SIGNATURE OF INTERVIEWER <i>John Doe</i>		18. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
19. SIGNATURE OF INTERVIEWER <i>John Doe</i>		20. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
21. SIGNATURE OF INTERVIEWER <i>John Doe</i>		22. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
23. SIGNATURE OF INTERVIEWER <i>John Doe</i>		24. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
25. SIGNATURE OF INTERVIEWER <i>John Doe</i>		26. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
27. SIGNATURE OF INTERVIEWER <i>John Doe</i>		28. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
29. SIGNATURE OF INTERVIEWER <i>John Doe</i>		30. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
31. SIGNATURE OF INTERVIEWER <i>John Doe</i>		32. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
33. SIGNATURE OF INTERVIEWER <i>John Doe</i>		34. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
35. SIGNATURE OF INTERVIEWER <i>John Doe</i>		36. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
37. SIGNATURE OF INTERVIEWER <i>John Doe</i>		38. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
39. SIGNATURE OF INTERVIEWER <i>John Doe</i>		40. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
41. SIGNATURE OF INTERVIEWER <i>John Doe</i>		42. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
43. SIGNATURE OF INTERVIEWER <i>John Doe</i>		44. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
45. SIGNATURE OF INTERVIEWER <i>John Doe</i>		46. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
47. SIGNATURE OF INTERVIEWER <i>John Doe</i>		48. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
49. SIGNATURE OF INTERVIEWER <i>John Doe</i>		50. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
51. SIGNATURE OF INTERVIEWER <i>John Doe</i>		52. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
53. SIGNATURE OF INTERVIEWER <i>John Doe</i>		54. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
55. SIGNATURE OF INTERVIEWER <i>John Doe</i>		56. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
57. SIGNATURE OF INTERVIEWER <i>John Doe</i>		58. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
59. SIGNATURE OF INTERVIEWER <i>John Doe</i>		60. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
61. SIGNATURE OF INTERVIEWER <i>John Doe</i>		62. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
63. SIGNATURE OF INTERVIEWER <i>John Doe</i>		64. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
65. SIGNATURE OF INTERVIEWER <i>John Doe</i>		66. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
67. SIGNATURE OF INTERVIEWER <i>John Doe</i>		68. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
69. SIGNATURE OF INTERVIEWER <i>John Doe</i>		70. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
71. SIGNATURE OF INTERVIEWER <i>John Doe</i>		72. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
73. SIGNATURE OF INTERVIEWER <i>John Doe</i>		74. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
75. SIGNATURE OF INTERVIEWER <i>John Doe</i>		76. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
77. SIGNATURE OF INTERVIEWER <i>John Doe</i>		78. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
79. SIGNATURE OF INTERVIEWER <i>John Doe</i>		80. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
81. SIGNATURE OF INTERVIEWER <i>John Doe</i>		82. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
83. SIGNATURE OF INTERVIEWER <i>John Doe</i>		84. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
85. SIGNATURE OF INTERVIEWER <i>John Doe</i>		86. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
87. SIGNATURE OF INTERVIEWER <i>John Doe</i>		88. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
89. SIGNATURE OF INTERVIEWER <i>John Doe</i>		90. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
91. SIGNATURE OF INTERVIEWER <i>John Doe</i>		92. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
93. SIGNATURE OF INTERVIEWER <i>John Doe</i>		94. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
95. SIGNATURE OF INTERVIEWER <i>John Doe</i>		96. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
97. SIGNATURE OF INTERVIEWER <i>John Doe</i>		98. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
99. SIGNATURE OF INTERVIEWER <i>John Doe</i>		100. SIGNATURE OF INTERVIEWER <i>John Doe</i>	